Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Prophylaxis of Tourists' Diarrhea

TO THE EDITOR: A group of tourists (mostly medical doctors and their wives) visited Egypt for nine days, stopping at Cairo, Luxor and Aswan. Because of a recent article on prophylaxis of tourists' diarrhea in the *New England Journal of Medicine,*[1] many of them took doxycycline (Vibramycin) 100 mg a day. Table 1 shows the results.

The woman who did develop diarrhea on a regimen of doxycycline had it mildly for half a day only. The others had it in varying degrees of severity lasting from one to ten days. For the purpose of classification only, cases severe enough to require medication were listed as diarrhea. There seemed to be no correlation between dietary precautions and illness. However, there were some cases of upper respiratory infections that were not prevented by the doxycycline. Although sunlight is said to cause reactions in patients receiving tetracycylines, the hot tropical sun of Egypt caused no problems.

In a family of four, only one member did not take the drug and she alone had diarrhea. It was a severe attack even though her only dietary indiscretion was the use of ice cubes. The doctors used a variety of medications as treatment for the diarrhea, especially diphenoxylate hydrochloride with atropine sulfate (Lomotil) and antibiotics. There seemed to be no correlation between type of therapy and duration or severity of the attack (see Table 2).

TABLE 1.—*Results of Doxycycline Therapy in 39 Tourists*

	Diarrhea	
	Yes	*No*
Taking doxycycline	1	13
Not taking doxycycline	17	8

TABLE 2.—*Results of Various Medications in Treating Diarrhea*

Medication	*Days of Illness*
Lomotil	7, 7, 8, 2, 10, 3, 5, 1
Lomotil and doxycycline ...	5, 2
Tetracycline	1
Paregoric and tetracycline ..	10
Cephalexin (Keflex)	4
No medication	1, 1
"Antispasmodics"	3

Egypt is a country of poor hygiene. Some 90 percent of the population at some time become infected with amoeba. The hotel facilities used were deluxe and a minimum of flies was observed during the trip. Those taking precautions drank bottled water imported from Italy. All other water used came from the Nile and it was impossible to get an honest assessment of what purification processes were used.

One has to conclude that doxycycline was an effective prophylactic for diarrhea in this group of tourists but apparently it is not effective as a treatment. One precaution should be mentioned: It must always be taken with food because it is quite irritating to the stomach. It is not known if other tetracyclines would have worked as well as the doxycycline.

MARTIN J. ROSTEN, MD
El Cajon, California

REFERENCE

1. Sack DA, Kaminsky DC, Sack RB, et al: Prophylactic doxycycline for travelers' diarrhea. N Engl J Med 298:758-763, Apr 6, 1978

Scombroid Poisoning

TO THE EDITOR: I read with great personal interest the very complete article in the November 1978 issue of the WESTERN JOURNAL by Lerke, Werner, Taylor, et al on "Scombroid Poisoning: Report of an Outbreak" and felt that I perhaps might be able to answer some questions raised by the authors. As a former fisherman and wholesale fish distributor employee, and presently supported by my father, a commercial tuna, bonito, mackerel (alas, scombroid) fisherman from San Pedro, I feel I might be able to bridge the gap

between the physician-epidemiologists and the fish providers. In their discussion, the authors raise two important points: (1) that histamine is produced at high temperatures, hence the question of how the fish were cooled ("whether they were put on ice or in a refrigerator") is of prime interest in understanding the epidemiology, and (2) the observation that histamine levels vary tremendously within the same fish.

In considering the first point, I feel the authors were unclear on the differences in storage between tuna that is held for "fresh" and that which is frozen for canning. As pointed out in their article, the choicer fish are reserved for the fresh fish trade. These fish usually are larger and are never stored for longer than three to four days. They are usually the "first-brailled" fish or those fish first placed in the hatch. These fish have not had the same chance to decompose as long as the other fish killed in the catch. They are then treated initially in the same way as the brine fish; that is, they are rapidly cooled to 28 to 32°F (this usually takes 12 to 18 hours). Then, for the fish intended for canning, sacks of salt are added and the fish are frozen. However, with the fish held for fresh sale, the water without added salt is maintained at 32°F and the fish remain chilled but not frozen. Hence, I believe the impression the authors leave that "the rate of cooling must necessarily have been considerably slower" is not correct. Having spent my undergraduate summers off the coast of Southern California fishing for tuna commercially, I know that fishermen, because of the economic incentive that fresh tuna bring, make every effort to rapidly chill but not freeze the tuna because firmness and rich color are the main qualities sought by wholesalers and sashimi consumers.

The second point made in the article, the very uneven distribution of histamine in the spoilage of fresh tuna, prompts an observation. In the Japanese tradition, the "belly" portion of the tuna is preferred and, therefore, gourmets of sashimi may well be affected more often by scombroid poisoning.

I hope my comments add to the excellent discussion on a rare but interesting epidemiological, pathophysiological and public health problem.

CHRIS PISANO
Fourth Year Medical Student, Class of 1979
University of California, Davis
School of Medicine
Davis, California

On Delineating Hospital Privileges

TO THE EDITOR: Time was when just being a good and conscientious physician was enough. We cared for our patients to the very best of our ability and everyone seemed satisfied. But nowadays that just does not suffice.

For example, this month at our community hospital staff meeting each physician was asked to fill out a sheet entitled "Delineation of Medical Privileges—Well Defined Category Approach."

In it we were asked to fit ourselves into category I, II, III or IV as to our ability to treat "organ systems or disease groups listed below." We were directed, in essence, to document for the hospital whether we considered ourselves first-class doctors or fourth-class doctors in the "privilege categories" related to disease entities ranging from allergy to rheumatology. Apparently, this information was to be on file in the administrator's office.

At last month's staff meeting we were handed a list (another paper to be filed in the front office) in which we were to check off a variety of procedures—spinal punctures, umbilical catherizations, circumcisions and so forth—that we were capable of doing, and that thereafter we would be allowed to do.

Month after month at staff meetings each committee and each department is asked, urged, required to spell out on paper its policies, to be entered in a policy book. And this policy book will be at every nursing station available for handy reference not only for the nursing staff, but for orderlies and nighttime cleanup crews, and conceivably for a plaintiff's attorney who may need a juicy bit of information.

If we have the temerity to ask why all this categorization and documentation is necessary we are told "Oh, it's required by the Joint Commission." If the mention of that august body is not enough, we are admonished "We have to take the hospital off the hook."

Unfortunately, most of us meekly comply, in the name of preserving our precious and sacred staff privileges.

Isn't it time that we practicing physicians awaken to the fact that each time we accept one more delineation of privileges or categorization of our capabilities, or that each time we etch one more policy in stone, we are actually painting ourselves into a tight little legal corner?

Isn't now the time to cry "enough"? Don't we